MINDPATH HEALTH

Professional Disclosure

Welcome to Mindpath Health! We are honored to support you on your journey to better mental health. Our team of providers offers a range of services that include diagnostic assessment, medication management, interventional psychiatry (including TMS and Esketamine) and counseling. For your convenience, we offer telehealth and in-person visits.

With a focus on total health, Mindpath Health is meeting people where they are, guiding patients on their journeys, and empowering them to live their most fulfilling lives. Our providers are licensed in the states where they practice. Information about licensure can be found on each state's licensing board website. To learn more about our providers, please visit us at mindpath.com.

Your Patient-Provider Partnership

The relationship between you and your provider is a collaborative endeavor built on trust and mutual respect. Together, you play a vital role in creating a care plan unique to your needs.

We know discussing difficult experiences can be uncomfortable. Your provider is here to create a safe space to promote your recovery and wellness. Open and honest communication with each other is key to building a successful partnership.

Because of the professional nature of this relationship, providers are prohibited from socializing with their patients. This includes following each other on social media. Sexual intimacy between a provider and patient is never appropriate. To protect patients and staff, we will not tolerate any verbal or physical aggression or harassment.

Beginning Your Journey

As a Mindpath Health patient, you or your child may receive clinical services from a psychiatrist, therapist, nurse practitioner, physician assistant, psychologist, counselor and/or social worker.

Your journey begins with meeting with your provider and discussing your concerns. By listening, asking questions, and taking notes, your provider will conduct a comprehensive clinical interview to learn more about you.

This initial assessment may be conducted over one or two sessions lasting up to 60 minutes each. With written consent, your provider may also request information from other health providers or schools to fully understand your needs.

Once the assessment is complete, your provider will provide a diagnosis and make treatment recommendations. You may also be referred to other health care providers according to your needs. Together, you and your provider will thoroughly discuss all options before agreeing on the best course of action.

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Child Patients

We know parents and caregivers need to understand and be involved with their child's care. Just like adult patients, children and adolescents want to know they can trust their providers. Because of this, providers may keep their sessions confidential unless they feel your child or someone else is in danger. State-specific legislation may also apply and in the case of alternative custody arrangements you will need to provide appropriate guardianship paperwork before proceeding with treatment. We encourage you to discuss with your child's provider how confidential information will be shared.

Medications

Our prescribing clinicians are committed to establishing collaborative, lasting relationships with their patients. The first visit with a prescribing clinician is an initial evaluation designed primarily for assessment and is not a guarantee of treatment or the prescription of medication.

Should you or your child consent to medication, your provider will monitor their effect during a series of follow-up sessions. During these sessions, your provider will work with you to gauge whether the medication is having its desired effect. At any time, you are encouraged to ask questions or raise concerns. Please note that some medications require blood work, EKG, or other tests to ensure they are safe for you to take.

Do not stop or change medication dosage without consulting your provider. Be sure to schedule regular appointments to ensure your medication can be refilled before you run out. Should you need a refill before your next appointment, please call your provider's office as soon as possible.

How To Reach Us

Where available, our patient portal is a convenient way to schedule and manage appointments, receive reminders, request medication refills, and send non-urgent messages to providers and staff. Alternatively, you can call your provider's office. Messages are returned within 72 hours, excluding weekends, holidays, or after business hours. Team members calling with appointment reminders will leave messages with the person responsible unless you request otherwise.
Should you have an urgent need after business hours, on weekends, or during holidays, please call your provider's office and follow the prompts. Your provider will make every effort to respond within 24 hours Monday through Friday, excluding holidays. In the event of an emergency, please call 911 or visit your nearest emergency room.

Requests For Substance-Use Disorder Treatment

Mindpath Health providers only provide treatment for substance use disorders in specialized programs. If you require substance use disorder treatment, please discuss options with your provider or reach out to your insurance plan for assistance in finding an appropriate treatment provider or facility.

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Insurance

We accept many insurance plans and will submit in-network claims on your behalf. While we are here to assist with this process, ultimately it is your responsibility to determine whether your insurance coverage includes mental health services from Mindpath Health.
Please note: many insurance companies will not cover two appointments on the same day (for example, with a psychiatrist and a therapist). Should this occur, you may be required to pay for one of these visits out-of-pocket.

Unattended Children

Unattended children are not permitted in our waiting area. Unless your child is being seen by a provider, please do not bring children to appointments.

Forms And Disability Requests

Please notify your provider at the beginning of your session if you have forms for them to complete. Paperwork needs are reviewed by the provider and completed at their discretion. This is based on a patient's needs, which are determined during the assessment. Providers may need several sessions to gather the information needed to accurately complete the request. Medical records or paperwork requests may be subject to additional fees and are dependent on state standards. Patients can obtain this information from the front office.

Patients seeking treatment for the sole purpose of obtaining disability or long-term disability benefits are not accepted. Providers may agree to complete short-term disability paperwork on your behalf, although they are not required. A separate appointment may be required to discuss your needs.

No-Show And Late Cancellation

Appointments may be cancelled at least one full business day in advance without incurring a fee. After three late cancellations or no-shows your provider may terminate care. Late arrivals have an impact on your care, and should you arrive late for an appointment, your clinician may reschedule your appointment to ensure you have the time needed. Please discuss appointment policies with your provider. Pursuant to federal law, Medicaid-funded patients are not charged for late-cancellations or no-shows.

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By signing below, I acknowledge that I have read, understand and agree to this Professional Disclosure.

Patient Signature _____ Date _____

Print Name _____ Patient Date of Birth _____

If you are signing this Professional Disclosure as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

☐ Parent ☐ Conservator ☐ Power of Attorney for Health Care
☐ Guardian ☐ Health Care Surrogate ☐ Executor / Administrator

Signature _____ Date _____

Name _____

MINDPATH HEALTH

Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices

Privacy Officer – 916-576-7900

Effective Date: February 22, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer at the number listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart. By law, the medical practice is required to ensure that your protected health information (referred to in this Notice of Privacy Practices as "PHI," "medical information" or "health information") is kept confidential. PHI consists of information created or received by the medical practice that can be used to identify you. It contains data about your past, present or future health or condition, the provision of health care services to you, or the payment for such services. The medical practice can use or disclose your PHI under the following circumstances:

1. Treatment. We may use or disclose your PHI in order to provide your medical care. For example, we disclose medical information to our employees and others within the medical practice who are involved in providing the care you need. In addition, we may share your medical information with other physicians or other health care providers who are not part of the medical practice and who will provide services to you. Or, we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. Payment. We may use and disclose PHI to obtain payment for the services we provide. For example, we might send PHI to your insurance company if required to obtain payment for services that we provide to you.

3. Appointment Reminders. We will use the home and work numbers that you provide to us in order to make or confirm your appointments. Unless you request otherwise, our staff will leave messages at these numbers with either appointment information or requests to contact us. We may also contact you to discuss your treatment, treatment alternatives or other health-related benefits or services we offer that may be of interest to you.

4. Health Care Operations. We may use and disclose your PHI as needed to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits (including fraud and abuse detection and compliance programs) and business planning and management. Under HIPAA, we may share your PHI with our "business associates" that perform administrative or other services for us. An example of a business associate is our billing services company. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your PHI.

5. Notification and Communication with Family. We may disclose to a family member, your personal representative or another person responsible for your care, the PHI directly relevant to that person's involvement in your care or about your location, your general condition or death. In the event of an emergency, we may disclose information to public service organizations to facilitate your care. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, we may use or disclose PHI when the law requires us to report abuse, neglect or domestic violence, respond to judicial or administrative proceedings, respond to law enforcement officials or report information about deceased patients.

7. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for public health activities such as: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; and reporting to the Food and Drug Administration problems with products and reactions to medications.

8. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

9. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your PHI in the course of an administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

10. Law Enforcement. To the extent authorized or required by law, we may disclose your PHI to a law enforcement official for purposes such as complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correctional institution as authorized or required by law.

11. Public Safety/National Security/Protective Services. We may, and are sometimes required by law, to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims and for other public safety purposes. Moreover, as authorized or required by law, we may disclose your PHI for national security or intelligence purposes or to authorized federal officials so they can provide protection to the President or other authorized persons or foreign heads of state.

12. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

13. Minors. If you are an unemancipated minor under California law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

14 Sale of PHI. We are prohibited from disclosing your PHI in exchange for direct or indirect remuneration unless we have obtained your prior authorization to do so.

15. Marketing. We must obtain your authorization before using or disclosing your PHI for marketing communications that involve financial remuneration. The authorization must disclose the fact that we are receiving financial remuneration from a third party.

16. With Authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Please note that although certain disclosures described above do not require your prior authorization under HIPAA, under California law we cannot make certain disclosures listed above unless you authorize the disclosure or the requesting party submits to you and us a signed, written request in accordance with Cal. Civ. Code §56.104. Moreover,

additional limitations exist with respect to our ability to re-disclose certain records that we receive from outside providers.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose PHI without your written authorization. If you do authorize this medical practice to use or disclose your PHI, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit, what limitations on our use or disclosure of that information you wish to have imposed and to whom the limits should apply. We reserve the right to accept or reject your request, unless you paid in full out of pocket for a healthcare item or service and you request that we do not notify your health plan that you have obtained such items or services. In that case, we must comply with your request. To the extent we have the right to accept or reject your request, we will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a post office box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. In such an event, we will notify you in writing of the reason for the denial, whether you have the opportunity to have the denial reviewed and if so, the process for reviewing the denial. In most cases, there is an opportunity to review the denial. We will comply with the outcome of the review.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You

also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your health information made by this medical practice for a period of up to six years. For example, we are not required to provide you with an accounting of disclosures made to you, for treatment purposes, made with your authorization and for certain other purposes. To obtain an accounting of disclosures, you must submit your request in writing. You are entitled to one accounting within any 12-month period. If you request a second accounting in a 12-month period, we may assess a reasonable fee.

6. Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

7. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

8. Paper Copy. You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer at the number listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice of Privacy Practices. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current Notice of Privacy Practices posted in our reception area. We will also post the current Notice of Privacy Practices on our website.

MINDPATH HEALTH

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. You will not be penalized for filing a complaint.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

Acknowledgment of Receipt of Notice of Privacy Practices

Privacy Officer – 916-576-7900

I hereby acknowledge that I received a copy of Mindpath Health's medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and on the medical practice's website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Signature	Date
Print Name	Patient Date of Birth

If you are signing this Receipt of Privacy Practices as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

☐ Parent ☐ Conservator ☐ Power of Attorney for Health Care
☐ Guardian ☐ Health Care Surrogate ☐ Executor / Administrator

Signature	Date
Name	

MINDPATH HEALTH

Consent to Treatment

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Mindpath Health for the purpose of diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Mindpath Health's providers include psychiatrists, psychiatric mental health nurse practitioners, physician assistants, psychologists, counselors, social workers, and marriage and family therapists. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor under the age of 13 and I am consenting to treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I understand that if I am a minor between 13 and 17 years of age, I have the right to alone consent to outpatient mental health treatment with Mindpath Health and therefore must sign this consent form in order to be treated by Mindpath Health. However, if I require prescription medication for my treatment, my parent or legal guardian is required to consent to the prescription of medication to me.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

If you are signing this Consent to Treatment as a parent, legal guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Legal guardian ❑ Health Care Surrogate ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name

MINDPATH HEALTH

Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Mindpath Health, and Mindpath Health's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**").

Community Psychiatry Management, LLC d/b/a Mindpath Health does not provide the Services; it performs administrative, payment, and other supportive activities for Mindpath Health and our Providers.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
  - asynchronous communications;
  - two-way interactive audio in combination with store-and-forward communications; and/or
  - two-way interactive audio and video interaction;
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;
- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;
- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Please contact your Provider's office to learn when telehealth services are available.
- Convenient access to follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by accessing your patient portal or calling the Provider's office directly.
- More efficient care evaluation and management.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT MINDPATH HEALTH OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE PROVIDER.**
- Our Providers are an addition to, and not a replacement for, your local primary care provider. Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate one if you do not.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact Mindpath Health at telehealth@Mindpath.com or 855-442-4580.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

MINDPATH HEALTH

Patient Acknowledgments:

I further acknowledge and understand the following:

1. Prior to the telehealth visit, I have been or will be given an opportunity to select a provider as appropriate, including a review of the provider's credentials, or I have elected to visit with the next available provider from Mindpath Health, and have been given my Provider's credentials.

2. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.

3. I may elect to seek services from a medical group with in-person clinics as an alternative to receiving telehealth services.

4. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.

5. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record.

6. Mindpath Health will take steps to make sure that my health information is not seen by anyone who should not see it. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state. I consent to Mindpath Health using and disclosing my health information for purposes of my treatment (e.g., prescription information) and care coordination, to receive reimbursement for the services provided to me, and for Mindpath Health's health care operations.

7. Dissemination of any patient-identifiable images or information from the telehealth visit to researchers or other educational entities will not occur without my consent unless authorized by state or federal law.

8. There is a risk of technical failures during the telehealth visit beyond the control of Mindpath Health.

9. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.

10. Persons may be present during the telehealth visit other than my Provider who will be participating in, observing, or listening to my consultation with my Provider (*e.g.*, in order to operate the telehealth technologies). If another person is present during the telehealth visit, I will be informed of the individual's presence and his/her role.

11. My Provider will explain my diagnosis and its evidentiary basis, and the risks and benefits of various treatment options.

12. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting Mindpath Health at: Medical.Records@mindpath.com. A copy will be provided to me at reasonable cost of preparation, shipping and delivery.

13. It is necessary to provide my Provider a complete, accurate, and current medical history.

14. There is no guarantee that I will be issued a prescription and that the decision of whether a prescription is appropriate will be made in the professional judgement of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.

15. There is no guarantee that I will be treated by a Mindpath Health provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.

Additional State-Specific Consents: The following consents apply to patients accessing Mindpath Health's website for the purposes of participating in a telehealth consultation as required by the **State of Texas**: I have been informed of the following notice:

NOTICE CONCERNING COMPLAINTS -Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353, For more information, please visit our website at www.tmb.state.tx.us.

AVISO SOBRE LAS QUEJAS- Las quejas sobre médicos, asi como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugia, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353, Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us

MINDPATH HEALTH

☐ **ACCEPT**. By checking this Box, I acknowledge that I have carefully read, understand, and agree to the terms of this "**Telehealth Informed Consent**" and consent to receive the Services.

Patient Signature	Date
Print Name	Patient Date of Birth

If you are signing this **Telehealth Informed Consent** as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

☐ Parent	☐ Conservator	☐ Power of Attorney for Health Care
☐ Guardian	☐ Health Care Surrogate	☐ Executor / Administrator

Signature	Date
Name	

MINDPATH HEALTH

Consent to Receive Emails & Text Messages

By providing your email address and telephone number to Mindpath Health you are agreeing to be contacted by or on behalf of Mindpath Health and one or more of our business partners identified below (collectively “Mindpath Health”) at the email address and the telephone number provided, including emails to your email address and text (SMS) messages to your cell phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice, and prerecorded messages, to provide you with marketing and promotional materials relating to Mindpath Health’s products and services.

You acknowledge this means Mindpath Health may transmit your protected health information, such as information about your appointments and other individually identifiable information about your treatment, via email or text (SMS) message. You further acknowledge that there are risks inherent in the electronic transmission of information by email or text (SMS) message, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered and that such information transmitted by email or text (SMS) message may be unencrypted.

You may opt-out of receiving text (SMS) messages from Mindpath Health or its subsidiaries at any time by replying with the word STOP from the mobile device receiving the messages. You need not provide this consent in order to purchase any products or services from Mindpath Health. However, you acknowledge that opting out of receiving text (SMS) messages may impact your experience with the service(s) that rely on communications via text (SMS) messaging.

Business partners:

Community Psychiatry Management, LLC
Mark David Levine, M.D., Professional Corporation
Mark David Levine, M.D. Psychiatrists, Professional Corporation
MindPath Health Care Centers, North Carolina, PLLC
Changes Counseling Center, LLC
Linda Berlin, Psy.D. & Psychological Associates, P.A.
Acacia Psychological Corporation
Center for Adult Psychiatry, LLC
Metropolitan Neuro Behavioral Institute, PLLC
Mindpath Health Ohio, LLC
Mindpath Health Arizona, LLC
MindPath Care Centers, South Carolina, LLC

MINDPATH HEALTH

I hereby consent to be contacted as set forth above.

Patient Signature _____ Date _____

Print Name _____ Patient Date of Birth _____

Email Address _____

Mobile Phone _____

If you are signing this consent as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Guardian ❑ Health Care Surrogate ❑ Executor / Administrator

Signature _____ Date _____

Name _____

Email Address _____

Mobile Phone _____

MINDPATH HEALTH

Consent to Obtain Medication History

Mindpath Health uses an electronic platform in its EHR (Electronic Health Records) to electronically prescribe medications to patients. Using this platform, providers can transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. Our Electronic Health Record also allows providers to obtain a patient's prescription medication history upon their consent. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

I hereby authorize Mindpath Health to request and use my prescription medication history collected from other healthcare providers, third-party payers (i.e. my insurance company), and pharmacies for treatment purposes.

I understand that this Consent to Obtain Medication History will remain in effect until I provide written notice of cancellation to Mindpath Health.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Consent to Obtain Medication History as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

☐ Parent ☐ Guardian ☐ Conservator ☐ Health Care Surrogate ☐ Power of Attorney for Health Care ☐ Executor / Administrator

Signature _____ Date _____

Name _____

MINDPATH HEALTH

Acknowledgment of Financial Responsibility

Please sign below to indicate your agreement.

Insurance authorization

I authorize Mindpath to act as my agent and disclose my health information to my insurance company to obtain payment for services rendered. I understand I am financially responsible for all charges not covered by my insurance plan. If I have a Medicaid plan, I understand I am only financially responsible for the copay and share-of-cost amounts.

Accurate insurance information

I agree to provide Mindpath Health with accurate and complete insurance information and to communicate any changes to my insurance information. I agree to pay for any cost that results from coverage lapses due to incomplete or inaccurate information.

Outstanding balances

If my balance becomes past due, I agree to comply with a payment plan if offered. I understand my provider may terminate treatment for non-payment. Accounts greater than 60 days may be referred to a debt collection agency.

Payment for minor patients

I understand that payment is expected on the date of service whether or not a minor is accompanied to an appointment. My credit card on file will be charged for services rendered.

Payment authorization

I authorize payment directly to my provider, and hereby assign my right to reimbursement for services rendered to Mindpath Health. I understand that my credit card on file will be charged for services rendered.

Payment by check

I understand that if two check payments are declined due to insufficient funds Mindpath Health will no longer accept checks as a form of payment. Additionally, I will be charged any fee associated with invalid checks.

I understand that this Acknowledgement of Financial Responsibility will remain in effect until I provide written notice of cancellation to Mindpath Health. I permit a copy of this authorization to be used in place of the original.

Patient Signature	Date
Print Name	Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Health Care Surrogate
- ☐ Power of Attorney for Health Care
- ☐ Executor / Administrator

Signature _____ Date _____

Name _____

MINDPATH HEALTH

Authorization For Disclosure of Health Information To Primary Care Provider

I hereby authorize Mindpath Health, it's staff and providers to:
(Please check all that apply)

☐ Disclose information to my Primary Care Provider

☐ Request information from my Primary Care Provider

Primary Care Provider's Name

Organization/ Medical Group Name

Office Address Street

City, State, Zip

Office Phone Number

Office Fax

Purpose of Disclosure

The purpose of the disclosure of my health information is:

☐ Care Coordination
☐ Billing/Payment Activity
☐ Treatment Planning
☐ Personal Use
☐ Legal

☐ Other (Specify):

_____

Information to be Disclosed

I authorize the following information to be disclosed:

☐ All of my health information and records, including information about my appointments, prescription medications and billing/payment for my care

OR

☐ Only the following information (specify):

_____

I authorize the disclosure of the following specially protected health information *(check and initial all that apply)*:

☐ Abortion
☐ Alcohol/drug treatment records
☐ Genetic test results
☐ HIV/AIDS test results
☐ Inpatient/residential mental health treatment information
☐ Pregnancy test results
☐ Sexually transmitted or other communicable diseases

MINDPATH HEALTH

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Mindpath Health in writing, except to the extent Mindpath Health has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Mindpath Health to disclose the information identified above.

I understand that Mindpath Health cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

_____

Email Address

If you are signing this Authorization For Disclosure of Health Information To Primary Care Provider as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

☐ Parent ☐ Conservator ☐ Power of Attorney for Health Care
☐ Guardian ☐ Health Care Surrogate ☐ Executor / Administrator

_____ _____

Signature Date

_____

Name

MINDPATH HEALTH

Credit Card Authorization

I authorize Mindpath Health to charge my credit card on file for amounts owed by me including co-pays, cancellations, and late fees. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement. I understand that this Credit Card Authorization will remain in effect until I provide written notice of cancellation to Mindpath Health.

Patient Signature _____ Date _____

Print Name _____ Patient Date of Birth _____

Name of Credit Card Holder _____

Credit Card Holder's Signature _____

If you are signing this Credit Card Authorization as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Guardian ❑ Health Care Surrogate ❑ Executor / Administrator

Signature _____ Date _____

Name _____

MINDPATH HEALTH

Patient Health Screen (Adult)

Patient Last Name: **First Name:** **Date of Birth:**

1. Please state the reason for making this appointment:

2. Have you ever been diagnosed with any psychiatric conditions? ☐ Yes ☐ No *If yes, please list below:

3. Please list all current prescription medication, over the counter medications and/or supplements you are taking:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

4. Please list past medication that you discontinued and for what reason:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

5. Please list any allergies to medications:

6. Please list any current medical problems:

7. Please list any major surgeries:

8. Please tell us about your current/past providers:

Do you have a primary care provider?	Have you ever seen a psychiatrist before?	Are you currently seeing a therapist?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	Therapist Name: Therapist Phone #: Therapist Location: Last visit date:

9. Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No *If yes, please list below:

Hospital name	City	Admit Date	Discharge Date	Reason for Hospitalization

10. Is there a family history of psychiatric conditions? If yes, please psychiatric condition(s) and your relationship:

11. Please list your use of:

	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol (For men, 5 or more drinks a day; For women, 4 or more drinks a day)	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Prescription Drugs for non-medical reasons	☐	☐	☐	☐	☐
Illegal drugs	☐	☐	☐	☐	☐

12. Please tell us more about yourself:

Education Level:	Employment:	Relationship:	Do you have children?
☐ Less than High School ☐ High School ☐ AA/AS ☐ Bachelors ☐ Masters ☐ Post Grad	☐ Employed ☐ Unemployed ☐ Student ☐ Stay at home parent ☐ Disabled	☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ Yes ☐ No If yes, please list how many:

13. Please list everyone who currently lives with you:

14. Are you currently dealing with significant financial problems (bankruptcy, foreclosure, large debt, etc.)?

☐ Yes ☐ No *If yes, please list below:

15. Are you currently dealing with significant legal problems (custody issues, divorce, DUIs, etc.)?

☐ Yes ☐ No *If yes, please list below:

16. Please list any other information you think is important for the provider to know:

Name of Patient

Today's Date

Patient's Signature